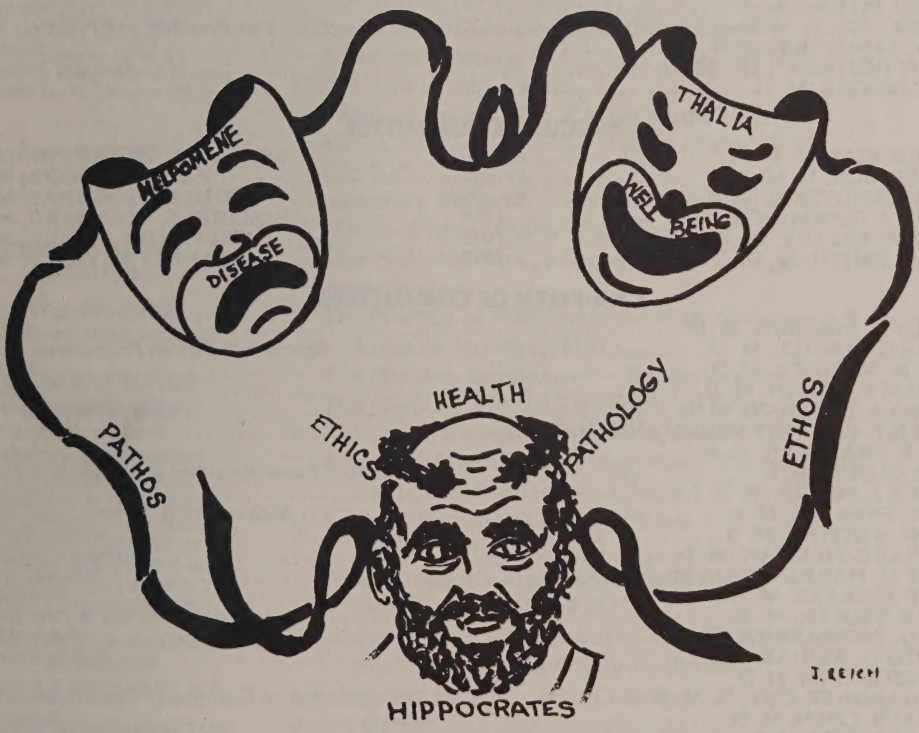
The Hampden Hippocrat

DECEMBER
1974



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THE HAMPDEN HIPPOCRAT · 1942 ·

VOL. XXX, NO. 10 DECEMBER 1974

Contents

Your President's Page — Bernard Bloom, M.D. — "The Changing Face of Medical Practice". 5
A Seasonal Poem — Mrs. James S. Fitzpatrick — "Christmas 1974" 7
Hilites of the HDMS Executive Committee — November Meeting 8
HDMS Scholarship Awards 10
The Page of the HDMS's Woman's Auxiliary — Mrs. J. Richard Chabot — Report of the White Cap Ball 11
Introductory Editorial — Walton E. Stevens, M.D. 'Ethos—Pathos, Ethics—Pathology, Thalia—Melpomene, a Connection??' 13
Featured Articles:
The Practice of Medicine — An Historical Jewish View — Louis A. Izenstein, M.D. 14
The Morality Component — Rabbi Alex Weisfogel 18
The Chaplain and the Terminally Ill Patient — Rev. W. Thomas Wilt, O.F.M, C.A.P. 19
A Simple, Profound and Magnificent Statement of Faith, Post Mortem — A Patient of the Editor 23
Faith, A Physician's Personal View — John J. Zadworny, M.D. 24
A Cardiologist's View of Medical Ethics — Jesse G. Hafer, Jr., M.D. 26
Medical Ethics: Will Physicians And Priests Ever Start Talking? Rev. Gary A. DeLong 27
Letter to the Editor — John C. Sevey 28
Poet's Corner 28
List of Advertisers (75 in all for '74)
Let Them Know You Saw Their Advertisement In The Hampden Hippocrat 30

The official bulletin for The Hampden District of The Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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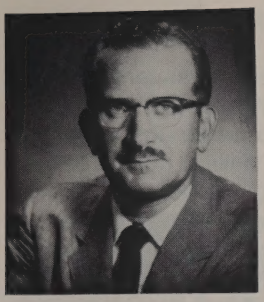


Your President's Page

The Changing Face of Medical Practice

First the "bad news" . . . Congress and the Administration have great and far-reaching plans in line for the health care establishment. And now the "good news" . . . These plans are still several years away from enactment and far from destroying the present methods of medical practice! However, don't sit back, physicians don't have time to tarry! What we need is to become fully informed about these plans and to support organized medicine's attempts to modify the restrictions on our practices which are already in the blueprint stages.

I would like to give our members a resumé of a recent HMO meeting, arranged by the local chapter of the Chartered Life Underwriters, to which your president was invited. The salient advantages brought forward in favor of HMO's were: 1. Great emphasis on preventive medicine; 2. Full range of medical services that affect the state; and 3. Increased efficiency in delivery of health care by having all medical services available at one location. Stress is to be given to ambulatory rather than hospital care. The present delivery system was categorized as a "non-systematized system." Note was made of the large amounts of capital required to start an HMO—for feasibility studies, planning, and finally implementation, hence the person for the insurance industry's entry.

Approximately 30,000 subscribers are required at the start, with buildup to about 50,000 to make the plan operate efficiently. It was said that there are over 300 functioning HMO's in the country now, with over 100 in California alone, about 35 in Minnesota, and with the rest scattered throughout the 50 states. Federally approved HMO's are much fewer in number and their growth is not expected to be more than 20 per year for the next 3 years. The federal concept HMO phrase was created only 4 years ago and already 8 million subscribers receive their medical care from these HMO's. The anatomy of an HMO consists of the providers, consumers, and financial resources. The providers include physicians, dentists, osteopaths, clinics, and group practices. The consumer is not just the patient, but includes healthy people in the preventive care program. A point made was that *good* health care is *better* health care and not merely more health care services. Life style problems, particularly in males between 45 and 64 years of age, such as cardiac disease, pulmonary emphysema, lung cancer, and hepatic cirrhosis are best treated by prevention rather than intervention. Stress is to be placed on follow-up care by the primary care physician.

The adversaries of HMO's were felt to be community hospitals which fear control by the HMO since present hospital plans and budgets could be thrown out of kilter, medical societies concerned with advertising by HMO's and finally HMO exception from Peer Review. However, recently HEW had declared that there is need "to assure that suitable procedures be applied to HMO services

(next page)

to assure that they conform to appropriate professional standards for the provision of health care applicable to other providers."

It was further stated that the majority of physicians were "disinterested or negative" concerning HMO's. The legislative and governmental aspects of HMO origins and planning were discussed. A five-year effort to determine whether HMO delivery system will be viable is backed up by $375 million dollars to be spent over the next 5 years for feasibility grants, planning grants, and finally implementation purposes. Strict requirements are placed on enlisting subscribers, to wit: The HMO must charge a community rate and it must provide for mandatory dual choice by individuals in organizations of over 25 employees. This feature gives the employees the option of joining a qualified HMO if one is available. The regulations are not fully written out by HEW and are not expected until late in 1975.

As noted in the October 28, 1974, **AMA News**, "HEW changed language to make it clear that an HMO may arrange for in-patient services, without providing them through an HMO-owned hospital. The requirement that mental health professionals direct the provision of mental health services was deleted and detoxification for alcoholism and drug abuse and referral to ancillary services must be offered." As noted above, the HMO's will definitely come under the PSRO authority, to insure quality medical care.

HEW states that basic HMO benefits must include:

1. Physicians' services (including consultant and referral services).
2. Outpatient services and inpatient hospital services.
3. Medically necessary outpatient and inpatient emergency health services.
4. Short-term (not to exceed 20 visits), outpatient evaluative and crisis intervention mental health services.
5. Medical treatment and referral services for the abuse of or addiction to alcohol and drugs.
6. Diagnostic laboratory and diagnostic and therapeutic radiologic services.
7. Home health services.
8. Preventive health services.

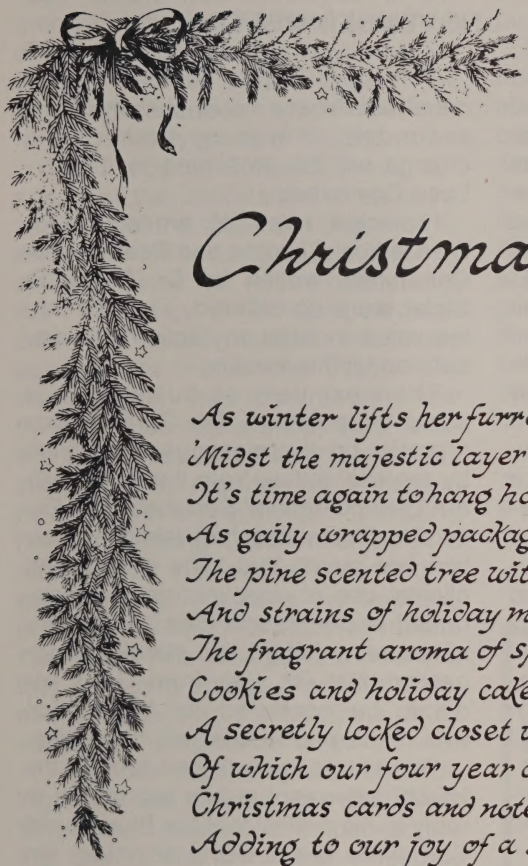
As you will readily agree (if you're still with me) that the above is a big order for an HMO to fill to become "qualified by the HEW." Is it not extremely important for medical societies to become fully involved and their members more knowledgeable concerning the implementation of HMO plans in their areas and nationally?

What about private practice as it is today, and the anticipated National health insurance plans? Fee-for-service will continue although it was felt that there will be increased pressure on fee-for-service solo practitioners, partnerships, and group to offer more services to patients in order to compete with HMO's. National health insurance will certainly include an HMO option and this will help increase the members of HMO's receiving financial assistance in becoming operational. Physicians may participate in HMO's part-time but technically there is a stipulation that HMO service must be the principal activity of its doctors. *That I believe should give us food for thought, since we might start out innocently as a contract, part-time physician only to be swallowed up by the HMO in time as deeper involvement makes increasingly greater demands on our time and energy.** We might have a 3 year respite since the regulations allow an HMO up to 3 years for phasing in period.

I believe the above is a fair appraisal of the state of our knowledge of HMO's at this time. Now, how many of us can afford to remain "disinterested or negative," as we have already described?

Bernard Bloom, M.D.
President

* (Editor's Italics)



Christmas ~ 1974

As winter lifts her furrowed head
'Midst the majestic layer of snow she's spread,
It's time again to hang holly over the door
As gaily wrapped packages arrive by the score ~
The pine scented tree with its many twinkling lights,
And strains of holiday music filling the nights ~
The fragrant aroma of special treats baking,
Cookies and holiday cakes in the making.
A secretly locked closet under the stairs
Of which our four year old is unaware.
Christmas cards and notes from our friends far and near,
Adding to our joy of a season so dear.
The crystal clear chimes of the church bells that ring,
Heralding the arrival of our New Born King ~
Christmas ~ to us ~ is all of these things.

Patricia K Fitzpatrick
SPRINGFIELD, MASSACHUSETTS
December 1974
Mrs. James G. Fitzpatrick

Hilites of the HDMS Executive Committee

— NOVEMBER MEETING —

The Executive Committee convened at 7:00 P.M. on Tuesday evening, November 19, 1974 in the Conference Room of the HDMS. Present were Drs. B. Bloom, C. W. Janovsky, E. I. Kraus, W. Hojnoski, R. A. Kelly, and Mrs. U. Purdy. Dr. P. McKenna and Dr. W. E. Stevens, were also present. The Hampden County Gynecological and Obstetricians Inc. had been invited to attend the meeting. Present from this medical group were Drs. Booker, Bettigole, Case , Kachinski, Pahl and Silva.

Dr. Bloom pointed out the balance between a news release and an advertisement. The significance of the articles which had appeared in several local newspapers were discussed by both sides. The OBS-GYN physicians indicated that the data in the article in the *Holyoke Transcript* was released by an RN working for them. For future release the publicity code of the MMS will be used as the guidelines. The group physicians, who attended as guests, were thanked and left.

Dr. Bloom, President, called the meeting to order at 7:30 P.M. The minutes of the October meeting were read and approved as read.

CORRESPONDENCE

Dr. Stevens, editor of the Hampden Hippocrat, had written requesting a HDMS By-Law change that would increase the Board of Editors to 12 members. After a motion duly made and seconded, it was so voted. This change will be presented to the By-Laws Committee.

Projected rules of procedure for the Medical Charges and Peer Review Committee, written by Dr. Bruce B. Stoler, were considered. The committee voted to table any action and discussion for this meeting.

The next item of business was about acupuncture. Dr. Gardner Cox reported on the meetings being held by representatives from the four Western District Medical Societies. The Executive Committee had taken a position last month that "The widespread clinical use of acupuncture is unwarranted at the present time." The committee reconfirmed this stand. A suggestion that Dr. Loh from Gary, Indiana, be contacted for an opinion was made and a letter will be written.

Dr. Aldo Leani responded to the HDMS letter sent to him last month in reply to his protest that the Blue Shield Committee is not doing anything. Dr. Magill had indicated that there was no special business before his committee at this time and therefore no reason for holding a meeting.

Dr. Bloom indicated that he would appoint a replacement for Dr. Fahy to the HDMS Council within the month.

Dr. Bloom had appointed Dr. James Fitzpatrick, Public Health Chairman,

(cont.)

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as HDMS representative to the meeting in Springfield Mayor Sullivan's office, which dealt with health care delivery in the Spanish community. Dr. Fitzpatrick attended this meeting and sent in a report. The major concept, which was developed at the meeting, was the need for a central agency which could coordinate the delivery facilities and strengthen the areas of inadequacy which now exist for this minority group of citizens.

The Executive Committee was apprised of the importance of early indications of the dates and chairman of the health fair to be held in the spring of 1976. Since this will be held during the Presidency of Dr. Cox, he indicated that he will make the necessary appointment in the near future. Dr. Harry Memery had forwarded the new by-laws to be approved by the Executive Committee and then the membership. Dr. Cox reported on a meeting held the previous evening, of the Long Range Planning Committee. Upon a motion duly made and seconded, it was voted to postpone the approval of these by-laws for another month. The reason for this postponement is that the Long Range Planning Committee is studying the functions of the various standing committees.

The cost of printing and distributing these new by-laws was discussed. Dr. Bloom suggested mimeo-graphing them.* The committee accepted this idea and the office secretary, Miss Joyce Whiting, will start. The membership will thereby be able to bring them to the next HDMS meeting for discussion.

Letters were read from the Bi-Centennial Committee concerning the exhibit "The World of Work." A letter of support is needed as is a donation of $400.00. A letter of support for the so-called "World of Work" (which would be an exhibit of a mock-up of an early American practitioner's office) will be sent to Mr. Alan Hale, Exec. Director of the Spfld. Bi-Centennial Committee. The donation must await Dr. Moore's budget report.

Mrs. Purdy reported a problem from the South End Community Center. A staff member of that Center had called asking for physicians to do Pap smears and breast examinations at a health screening testing to be done on Dec. 3, 1974 from 2:00 to 6:00 p.m. Although the physicians from the Riverview project are participating in this project, it is felt that the 2 week lead time was much too short for the HDMS to find physicians to assist. Therefore, the S.E.C.C. staff member will be so informed.

There was no further business and the meeting was adjourned at 9:25 P.M.

Carl W. Janousky, M.D.

* The by-laws will then be distributed in *The Hampden Hippocrat.*

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THE PAGE OF THE HDMS'S WOMAN'S AUXILIARY

Congratulations to Grace Stirlacci and her most able committee for a job well done—the 1974 White Cap Ball was an enormous success. Everyone would agree it was a most delightful event—and it also proved to be an unequaled financial success with a final profit of $4032.00. That is a real boost for the scholarship fund. The dinner-dance itself was well-attended and brought in a profit of $1113.00. The donations came to $1165.00 and Grace wishes to thank all of you who so generously gave to this most worthwhile cause. The raffle was indeed a popular innovation this year and realized a profit of $1761.50. The credit for this bonza goes to Carol Yorzyk—Thank you Carol. I think the raffle should be here to stay—! Among this year's lucky winners are: Dr. and Mrs. Richard Lavin, Mrs. Bernard Bloom, Mrs. Gregory Gallivan, Mrs. Romeo Roque and members of her family, Dr. Paul Ashton and Dr. Leandre Giguere.

In summary, the White Cap was a great evening—hope to see you all there in 1975.

Del Chabot, Publicity
Mrs. J. Richard Chabot

EDITOR'S NOTE:

The entire staff and all the officers are to be congratulated on an excellent and fun evening. Their hard work was obvious and their dedication comforting. Regardless of what is said about physicians and their nights out, this was one to which we all can be proud. The students who will benefit from these funds will be the intermediate beneficiaries—our patients, the last.

WELL DONE, LADIES! The Editor

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THE SURE THING

Ethos—Pathos, Ethics—Pathology, Thalia—Melpomene, a Connection??

Again this issue of your Hampden Hippocrat has concerned itself with humane concepts of the interrelationship of medicine and religion. Three members of the Hampden District Medical Society and three members of the religious community of greater Springfield have contributed the featured articles. Each in his own way relates the interdependency of one to the other—Man and his God; physician, patient and clergy. The medical team effort to restore or ameilorate disease must go hand in mind with the council, faith and teachings of the Divine Being, as interpreted by the various faiths. The healing Arts have always invoked Divine assistance and will continue to do so.

The American Heritage Dictionary of the English Language, 1970 Edition, Published by Houghton, Mifflin Company gives as some of its interpretations and definitions, the following:

"*Ethos*—1. The disposition, character, or attitude peculiar to a specific people, culture, or group that distinguishes it from other peoples, or groups; fundamental values or spirit; mores.

Pathos—1. A quality in something or someone that arouses feeling of pity, sympathy, tenderness, or sorrow in another.

Ethics—2. The rules or standards governing the conduct of the members of a profession. . . . 4. The moral quality of a course of action; fitness; propriety.

Pathology—1. The scientific study of the nature of disease, its causes, processes development and consequences. 2. The anatomic or functional manifestations of disease."

The contributors to the featured articles do reveal their *pathos* to patient *pathology* and they indicate the limits of the *ethics* of their professions. All speak for a *new ethos,* or perhaps a revival of a forgotten *ethos,* to be used in the care of patients in this period of our medical practice. Thus, these Greek derived words and their connotations seem to have a connection and that connection is, as suggested, the inter-action of physician, patient and clergy. The results of such an interaction would go far to determine the intensity of control dictated by disinterested (?) "scientific" parties and politicians. Therefore, I would prudently suggest that the Hampden District Medical Society, through its President Dr. Bernard Bloom and the chairman of the medco-religious committee, Dr. Lewis W. Whiting, call for a convocation of the various leaders in the medical and religious communities, to develop a working ethos for all our patients. This *ethos* to be publicized via appropriate media and from our denominational pulpits and the distillate there from, to be applied to our current codes of ethics. Our patients would then be aware of current medico-religious *ethos—pathos* and thereby feel freer to discuss their needs and desires, when a particular pathologic process destroys their good health and well being.

The cover diagrams the Greek masks associated with two of the nine Muses —Thalia and Melpomene. Our own Hippocrates completes the triad. Perhaps, Clio and Erato should also be represented for completeness in this brief allegory. The physician (Hippocrates) is continually pulled between a need to make a happy, healthy patient (Thalia) and the realization that man is mortal and not all disease is curable (Melpomene). Ethical codes and his own *pathos* will dictate what and how he conducts his relationships with the patient and the family. When the need and the realization can not be successfully fused, the physician may remain silent and not communicate with his patient, just at the time when that communication is most vital to the patient. Without communication by the physician to the patient's clergyman, the clergyman can not properly relate and relieve the anxiety of the patient-parishioner. A new ethos for our area and our times will be appreciated by all. A pathway would be opened for physician, patient and clergy to talk openly, one to the other.

A healthy and happy New Year to us All.

The Editor-in-Chief

Featured Articles:

THE PRACTICE OF MEDICINE — AN HISTORICAL JEWISH VIEW

Much has been written about the influence which Jewish people during their long history have exercised upon the science and the practice of Medicine. There are many works on the Medicine of the Bible, on the Medicine of the Talmud, on the history of Jewish physicians, and on their contribution to Medicine. Aside from a few diseases to which the Jewish people are prone, there is no such concept as Jewish Medicine—but rather Jewish Physicians who are practicing the Art of Medicine and contributing to its development and progress—ministering to the sufferings of each and all members of the human race. Suffice it to record here that the contributions have been many—statistically, Jews account for over 30% of all Nobel Prize recipients in Medicine, while they constitute less than 0.3% of the total world population.

From ancient times, Medicine and the Jewish religion have been closely allied. Very aptly has Moses been referred to as the "First Public Health Officer." The long line of Priest—Rabbi—Physicians is an indication of the importance attributed to Medicine. The leading thinkers, Rabbis, Priests, Philosophers practiced Medicine in their time (men such as Maimonides, Judah Halevy, Abraham Ibn Ezra, and Judah Ibn Tibbon). The dispute as to the propriety of human interference in sickness—regarded in ancient times as divine retribution—ceased to trouble the Jews, because they came to regard the physician as the instrument through whom God could effect the cure. In fact, Maimonides, the most learned of the Rabbi-Physicians, makes a major pronouncement that the physician has permission to heal—nay, more, he is obligated to heal—based on the Biblical Verses: "And cause him to be completely healed" (Exodus 21:19) and "Neither shalt thou stand idly by the blood of thy neighbor" (Levit. 19:16). To save life is considered a supreme duty. The supreme and infinite value attached to human life in Judaism is reflected by the automatic suspension of all religious laws if necessary to save life. As the Talmud puts it, the ordinances of the Torah were given, "That man shall live by them, not die by them." Accordingly, the violation of the Sabbath laws, for instance, in the face of danger to life, is not only permitted, but mandatory. The Jewish law raises the healing of the sick into a religious precept. Any person who has the power to save life and does not exercise it, or who stands idly by when a life is in danger, offends against the law. Hence a Doctor may never refuse or withdraw his services, even if other Doctors are available, unless they are more competent. Human life is valued as infinite. The human being reflects the holiness of God, for "In the image of God made He Man" (Gen. 1:27). It is Jewish thinking that it is man's duty to conquer disease just as it is his duty to conquer poverty and the ills of society.

No people has more consistently shown its regard for the profession of medicine than have the Jews. They have devoted themselves to medicine as a favored profession in all the ages of their history. They have laid down the rules of ethical conduct that have never been excelled. Their scorn for the quack and the charlatan was as intense as their admiration and respect for the "Faithful Physician"—a term which, in greatest reverence, they applied to God.

(cont.)

How beautifully this was depicted in the wisdom of Ben Sirca, (Eccles. 38) Third Century B.C., herein summarized in four beautiful pithy poems:

Honor a physician before need of him
Him also hath God apportioned

From God a physician getteth wisdom
and from a King he shall receive gifts

The skill of a physician shall lift up his head
and in sight of great men he shall be in admiration

God bringeth out medicines from the earth: (Waxman) Streptomycin
And let a prudent man not refuse them
Then give place to the physician, for the Lord created him.

Asoph Haropeh, a leading physician of the 6th century, popularized the concept that the learning of medicine was for the Elect, those possessing lofty qualities, who had gone through difficult tests and had shown that they were fit to be accepted into the academy of men of superior intellect and high character. Asaph saw in medicine the extraordinary amalgamation of science, art and ethics.

Very interesting statements bearing upon the ethics of medical practice are to be found in the "Aphorisms" written by Isaac ben Solomon Israeli (830-932). Translation of a number of the aphorisms follow:

1) "As the science of medicine is so extensive and the life of man too short to attain the whole, physicians of experience must be separated from the foolish, they must "purify themselves, make themselves white and be refined" (Daniel 12:10), for by their constant study of literature and ceaseless investigations they distinguish themselves from the rest of mankind."

2) "It is fitting that he who is engaged in the cure of human bodies (which are the most precious of all creations of this world) consider and examine carefully the diseases that may occur, and give directions after mature deliberations and considerations so that he makes no irreparable error. Therefore, if ye find a physician who is ready as soon as asked to give information about every disease and particularly to praise his own methods of treatment, ye may regard him as a knave."

3) "The physician does not bring the cure, but he prepares and smoothes the way for nature; nature is the actual healer."

4) "The need of the physician is twofold, preserving health and curing disease; and the demand for the former is greater than for the latter; for it is better for man that he avoid being ill than that he become ill and be cured."

5) "Endeavor in thy treatment always to use simple drugs, for it is easier for thee to acquire the knowledge of their action than that of the complicated ones."

6) "Suffer not thy mouth to condemn when something happens to a physician, for every one has his evil day. Let thy deeds praise thee, and seek not thine honor in another's shame."

7) "Too large a practice confuses the judgement of the physician and causes him to give mistaken directions."

(cont. next page)

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There are 613 Commandments of the Law which the observant Jew must obey. Of these, 213 are of a medical nature. With the ever changing problems of the times, with the expanding horizons of medical progress—advances which often raise moral and religious problems of the utmost gravity, it is not surprising that a voluminous literature of Responsa—queries and answers—has developed. These shed new light on old problems and investigate ways and means of applying the rules of Judaism to contemporary conditions. Interpretation of these Responsa is best left to the Rabbis—who can then join with the Ethicists in search of the right answers to current issues, not merely on the basis of scientific inquiry, but also on the basis of ethical and moral discipline—for the Good Society. (See Hippocrat Dec. 1971.)

Of recent years the relevance of the Hippocratic Oath has been questioned. In fact, it has been replaced in some medical schools by the Oath and Prayer of Maimonides. Historically, this prayer was probably not actually written by Maimonides but rather by Dr. Marcus Herz (1747-1803). It emphasizes the ethical and moral responsibilities of the physician in the alleviation of human suffering. While it recognizes God as the ultimate Healer of disease, it also emphasizes the indispensible part played by the physician, his art and his medicines in the "Harmonious preservation in all its beauty of the body, which is the envelope of the immortal soul." It is the oath of membership of the local Maimonides Medical Society. On account of its intrinsic value, it is appended here in an English translation.

Almighty God, Thou has created the human body with infinite wisdom. Ten thousand times ten thousand organs hast Thou combined in it that act unceasingly and harmoniously to preserve the whole in all its beauty—the body which is the envelope of the immortal soul. They are ever acting in perfect order, agreement and accord. Yet, when the frailty of matter or the unbridling of passions deranges this order or interrupts this accord, then forces clash and the body crumbles into the primal dust from which it came. Thou sendest to man diseases as beneficent messengers to foretell approaching danger and to urge him to avert it.

Thou hast blest Thine earth, Thy rivers and Thy mountains with healing substances; they enable Thy creatures to alleviate their sufferings and to heal their illnesses. Thou hast endowed man with the wisdom to relieve the suffering of his brother, to recognize his disorders, to extract the healing substances, to discover their powers and to prepare and to apply them to suit every ill. In Thine Eternal Providence Thou hast chosen me to watch over the life and health of Thy creatures. I am now about to apply myself to the duties of my profession. Support me, Almighty God, in these great labors that they may benefit mankind, for without Thy help not even the least thing will succeed.

Inspire me with love for my art and for Thy creatures. Do not allow thirst for profit, ambition for renown and admiration to interfere with my profession, for these are the enemies of truth and of love for mankind and they can lead astray in the great task of attending to the welfare of Thy creatures. Preserve the strength of my body and of my soul that they ever be ready cheerfully to help and support rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being. Illumine my mind that it recognize what presents itself and that it may comprehend what is absent or hidden. Let it not fail to see what is visible, but do not permit it to arrogate to itself the power to see what cannot be seen, for delicate and indefinite are the bounds of the great art of caring for the lives and health of Thy creatures. Let me never be absent-minded. May no strange thoughts divert my attention at the bedside of the sick, or disturb my mind in its silent labors, for great and sacred are the thoughtful deliberations required to preserve the lives and health of Thy creatures.

(cont.)

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Grant that my patients have confidence in me and my art and follow my directions and my counsel. Remove from their midst all charlatans and the whole host of officious relatives and know-all nurses, cruel people who arrogantly frustrate the wisest purposes of our art and often lead Thy creatures to their death.

Should those who are wiser than I wish to improve and instruct me, let my soul gratefully follow their guidance; for vast is the extent of our art. Should conceited fools, however, censure me, then let love for my profession steel me against them, so that I remain steadfast without regard for age, for reputation, or for honor, because surrender would bring to Thy creatures sickness and death.

Imbue my soul with gentleness and calmness when older colleagues, proud of their age, wish to displace me or to scorn me or disdainfully to teach me. May even this be of advantage to me, for they know many things of which I am ignorant, but let not their arrogance give me pain. For they are old and old age is not master of the passions. I also hope to attain old age upon this earth, before Thee, Almighty God!

Let me be contented in everything except in the great science of my profession. Never allow the thought to arise in me that I have attained to sufficient knowledge, but vouchsafe to me the strength, the leisure and the ambition ever to extend my knowledge. For art is great, but the mind of man is ever expanding.

Almighty God! Thou hast chosen me in Thy mercy to watch over the life and death of Thy creatures. I now apply myself to my profession. Support me in this great task so that it may benefit mankind, for without Thy help not even the least thing will succeed.

Louis A. Izenstein, M.D.

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The Morality Component

Times in which dramatic changes take place are not the best vantage points from which to evaluate their long range effect on human society. Nevertheless, value judgements, structured on moral and ethical criteria must be made of those changes in the here and now without the benefit of historical perspective. But those same moral and ethical judgements will be reexamined, at a later date, and praised or damned, accepted or rejected on the basis of subsequent experience.

In no period of history have sensational scientific developments crowded each other out of the headlines as fast and as furious as they have been doing in this second half of the 20th century. It is almost as if every day, in recent memory, has launched a new era for scientific man. The vast volume of intensive research and experimentation already under way dictates that the pace of innovation will accelerate rather than diminish in the foreseeable future. This is certainly no less true of the science of healing.

To complicate matters, mass media has a tendency to prematurely glamorize developments. It is not uncommon for a gullible patient to come seeking a specific "miracle" treatment before the physician has had an opportunity to study and determine its medical effectiveness, not to speak of its moral and ethical implications. The medical community can thus find itself confronted by a world outside that is prepared to dictate to it the right, the ought, and the must without, it seems, the benefit of the physician's special expertise and intuitions. If the doctor would consider this meddling one might be inclined to defend his attitude.

Furthermore, the claim of infallibility in moral judgements by certain special interest groups, or even spokesmen for the religious establishments of our various denominations, hardly seems valid to him, particularly since those who speak in the name of divine law do not all agree with each other. At times their views are even diametrically opposed to each other. Obviously two conflicting pronouncements cannot both be infallible. Theologians will confirm that not everything is really spelled out in Biblical commandments. Scripture condemns Cain for the murder of his brother Abel although at no time prior to the act was he informed that taking another human life is sinful. It seems that the sacred book is saying that certain decisions based upon man's own intuition of right and wrong should dictate even in the absence of divine injunction.

Is the physician less qualified to apply that intuition? The answer is of course no. He is not less qualified. But what must however be demanded, as a prerequisite, is that morality and ethics have some role in the decision he makes. At times when one reads of new developments one wonders whether the particular innovator has allowed those values to enter into his calculation and decision. There seems to be abroad an opinion that for the most part the advancement per se of the science of medicine is in itself to frequently considered the ultimate good.

If we were to concede that the physician himself is the best qualified individual to evaluate the rightousness of his actions, then it is his onus to demonstrate that moral imperatives are an influence upon his decisions. In this age of speed, the tomorrow of history in which today's actions will be reexamined and reevaluated is already here before the day is passed. Rabbi Alex Weisfogel

Ernest A. Byron, Jr.

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SPRINGFIELD

The Chaplain and the Terminally Ill Patient

The church's theological understanding of human illness and recent scientific discoveries indicate a correlation between the physical and non-physical aspects of human suffering. Scientific research has shown us that the complete treatment of any physical disorder must also take into consideration the psychological ramifications of that illness. The church adds to this her concern for the spiritual well-being of ailing members. Thus, the sacrament of the sick encompasses a concern for all aspects of humanity which are affected by physical sickness. The anointing and prayer of faith is intended for the whole person, physical, mental and spiritual and its healing effect may be found in any or all of these aspects of the human person.

The first thing which must be done, is for the person who is to minister to the terminally ill patient (whether the minister be priest, religious, parish minister or rabbi) to come to grips with his own attitude toward death and dying. Just as a person who faints in the presence of sickness would not be a suitable minister for the sick, so too, a person who cannot cope with death and dying would not be a suitable minister to those terminally ill. Some type of personal accommodation with one's own death is a basic first step.

Next, should a person who is suffering from terminal illness be told? There are several points to be made here: first, a person should be told that they are seriously ill, what is being done, and what is hoped to be accomplished; second, any question of the patient should be answered truthfully. Much depends upon the patient and the sensitivity of the minister. Sometimes a patient is aware that something serious is going on, and will drop hints that he wants to be told. Others will ask outright and insist on knowing, while others will not want to know, and may not be ready to face the news at that particular time. Such people make absolutely no reference to their illness, or say that they don't want to know about it. The minister must show interest in such a patient, and give him time and concern. When a period of time has elapsed and there is no improvement in the health of the patient, he will begin to question. If a relationship has been built up by then between the patient and the minister, the minister will then be able to help the patient face his own situation; the ill person will not have to do it alone.

(next page)

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In working through and supporting the dying patient, the minister should be aware of the mechanisms that have been found to be used by the dying. Among these are devices or stages called **denial** (isolation), **anger, bargaining, depression,** and **acceptance** (for a fuller treatment of this entire question that is outlined here, cf. Elizabeth Kubler-Ross. *On Death and Dying* (New York: Macmillian, 1969), and her *Questions and Answers on Death and Dying* (New York: Macmillian, 1974). These do not necessarily follow in order, but with practice and sensitivity, a person can usually see what stage a patient is passing through, and relate to him there. These stages are fluid, and a person may move back and forth among them; even after reaching the final, acceptance stage, a person may then shift back to another stage. In **the first stage of denial or isolation,** the patient, after having been told, is often heard to say, "No, it can't be true. I don't believe it." Some patients will seek medical opinions in hopes that the decision will be reversed. Others will refuse medications because they say they are not sick and do not need them. Diets will be broken and foods that will do them harm are taken freely, which many times only makes their suffering more acute. Then there is the patient who takes upon himself the burdens of all the other patients as if he had none of his own. He will make plans for the future which he could not possibly fulfill. Others will refuse to make any plans for their family's future in the light of their passing. Some, after hearing the verdict will refuse to talk about their illness with anyone.

How do you help a person in this stage? First, a relationship of trust and honest concern must be built up between the patient and minister. No one discusses such things so personal with a stranger or someone who pops in and out of his room. When trusted, the minister can effectively point out the importance of taking medication, or sticking to a diet, etc. He can question quite realistically the plausibility of the plans that are being made, or point out the neglect of those that should be made. Gently, but firmly, the patient must be faced with reality and given every opportunity to talk about it for as long or as short a time as he wants.

The denial stage usually leads to **the stage of anger.** This is manifested mainly by the patient finding fault with the nurses and doctors, the way treatment is done, the food that is served and sometimes even with his family. Some questions that are verbalized might be "Why me?" "What did I do?" "Why is God punishing me?" Their anger is manifested towards those that help them because these people represent health, vitality, strength, and life, which is being denied to them because of their illness and which they will never be able to regain. The patient must be given the opportunity to express his anger and helped to see why he is angry. He must never be told he is wrong to feel this way. Those working with the patient must realize their presence is a constant reminder to the patient of what he will never have again, and they in turn must have patience and understanding of his plight.

(cont.)

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The bargaining stage is where they promise good behavior or a change of life if only they could have more time to live. These are usually private promises or shared only with a person very close to them.

The depression stage can be of two types, both of which are dealt with in a very different way. The first is a depression experienced because of concern for the well-being of those left behind or financial worries that are pending because of long hospitalization. Here the nurse, social worker, and minister can work together in helping him settle these very real problems and in so doing, relieve him of this burden. In the other type of depression, he no longer denies his illness, his anger has been vented, he has tried to bargain without success and now he sees himself losing all that is dear to him in life. It is his initial step in separating himself from life. He will be experiencing great sorrow and should be permitted to express this sorrow. It is not the place of the minister to make him happy, cheer him up, or tell him he still has these things. Rather, the patient must be allowed to experience this loss, for this is preparatory to acceptance. As the patient experiences this separation, words are not always needed, but presence is vital. Just holding the patient's hand for what might seem an interminable time speaks volumes to him. He is thus able to work it out within himself knowing that someone is there to help and to understand.

The stage of acceptance must not be looked upon as one of joy. There is a peace and resignation that is quite evident. He will be heard to say that he cannot fight anymore. He will probably sleep more. He is ending his struggle and his energies are spent. He will ask for prayers, or to be prayed with, because he looks to to the future beyond this life. He has settled his life here on earth and waits peacefully for a new beginning. The family may find this stage very difficult because they might interpret it as despair. They must be helped to see it through the eyes of the patient, and be assured that he is at peace with himself and for him, this is the most important thing. The best service the family can do is to visit, and to spend time in a quiet atmosphere and show the patient that he is still a very important person. He is assured of their time and presence right to the end. He is able to face death as a person with dignity.

The family of such a patient will certainly need our attention. At such a critical time, they will need someone to share their feelings with, someone to help *them,* for it is the hour of their need too. The importance of their love for the patient must not be allowed to go unnoticed, and they may need help to express it honestly and deeply. They should be made aware of the different stages that the patient may pass through. With the cooperation of the nursing staff, they may even be encouraged to help in the daily care of the patient (when this is possible). The opportunity to do something constructive for the patient is usually welcomed by the family. Both of these dimensions to pastoral care of the sick are obvious, but they are the foundation of it too. The person who is ill needs the best ministry we are capable of giving him, and the family is a too often neglected dimension of this ministry.

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Ministry to the sick cannot be conducted in a vacuum; it will often demand the cooperation of the hospital or medical staff. Sometimes, our ministry will have to be directed to them, for they are the ones who spend most of the time with a patient, and deal with him most often. A ministry to hospital or medical staff can lead to an extension of our own (hence, of Christ's) ministry to the sick. Such a ministry should not be confined to the formal meetings which take everybody off the floor, but should also live on the day by day informal contact of people dedicated to the care of the sick, whether over lunch or coffee. An important dimension of this ministry will be to remind the staff that their efforts are directed to people, not simply cases or problems. Recently, a doctor's mother died after a prolonged dying process which consumed months. The following week, he admitted a person with an advanced cancer, seventy years old. His treatment of her was very conservative, comfortable, and willing to accept her imminent death. By radical means, he could have prolonged her life for three months, but it would only have prolonged her suffering. From his experience with his mother, he was able to see the person in his patient. This is not to say that medical personnel should become the slaves of empathy and be paralyzed by the struggles and sufferings which they perceive. The minister to the sick should help develop an adequate blend of personalism and professionalism.

Seeing the sick as persons will help them to see their worth. The staff will learn from the sick as few people do, for the sick will remind them of their own mortality, faility, weakness, and humanity. The blind will show them (and us) our lack of vision; the weak will remind us of our lack of strength; the paralyzed will portray our lack of motion; and the deaf will shout out about the hardness of our hearts which hear, but not always listen. Such perceptions will be invaluable to all concerned.

"All mortals are like grass;
all their splendour like the flower of the field;
the grass withers, the flower falls;
but the word of the Lord endures for evermore."

And this "word" is the word of the Gospel preached to you. — 1 Peter 1:24-25

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A Simple, Profound and Magnificent Statement of Faith, Post Mortem

Die Gottheit oder das Schicksal hat beschlossen, dass mein Leben am October 29, 1974, zu Ende ist. Ich füge mich darein.

Aber das Leben war schön. Da war zuerst die Arbeit. Viel gute, ernste Arbeit, die ich gern getan habe; denn nichts befriedigt den inneren Menschen als wie eine Arbeit mit bester Kraft getan.

Und dann gab es viele liebe Freunde, die das Leben schöner und reicher gestalteten. Ihnen sei Dank hier.

Auch an die Natur denke ich: die liebe, warme Sonne und der Mond am gestirnten Himmel, die Tiere und die Blumen. Wie schön sie alle waren. Sie haben mein Herz beglückt.

Leider muss ich nun von ihnen scheiden.

H.K.H.

Deity or Fate has decided that my life is to come to an end on October 29, 1974. I submit gratefully, for life was beautiful.

First there was work, interesting work. Nothing satisfies the inner self as work, done with one's best effort.

Then there were many good friends, who made life richer and warmer. I thank them now with all my heart for this precious gift of friendship.

Also of nature I think, the warm golden sun, and the moon in the starry heaven, the animals and the flowers. How they gladdened my heart.

I must leave them all now.

H.K.H.
From a patient of The Editor.

- AGAPE -

This patient was aware that her span of life was coming to its end, she had lived into her eighty ninth year and survived a carcinoma of the cervix, but succumbed to breast cancer. She was in full control of all her faculties and composed the above message to her friends, her companion had only to fill in the appropriate date. Would that we all could face life and death in her manner!

The Editor-in-Chief

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Faith—A Physician's Personal View

As a physician, I find there often is a great deal of tension between my scientific knowledge and my religious faith. As a result my life represents a mixture of the human element with the divine element, of the material element with the spiritual element and of the finite with the infinite. This mixture produces many conflicts and thus, many pressures.

I believe that in the beginning all men were formed from the earth and that we are obliged to live with the earth and on the earth. I also believe that we are all spirited by some Divine breath of life. As I work with my hands, as I use my imagination, as I use my intellect and my decisions, I feel that I am being impelled by some Divine force.

Even when I perform my humanly best I feel there is a Divine source of vitality which leaves me not fully satisfied. This drives all of us to try to exceed our earthly and human possibilities and this tension or struggle which is the inevitable result—but this impulse to step beyond the human is the movement or beginning of our faith. Thus my faith is a recognition that the Almighty demands more than that what man is capable of performing by himself and faith then becomes the commitment of oneself to the Divine will. It will inspire the confidence that will sustain us, guide us and perfect our step into the unknown. Possessing this faith does not result from abdicating our intellectual activity but on the contrary our faith becomes strongest when our minds are pushed to its limits. The more I strain for the fullest intellectual endeavor the more I realize the great might and wisdom of a Divine Being and therefore at my very best I feel as discontentment which engenders new hopes and ideas.

Where does wisdom fit into this scheme of human endeavor to follow the Divine inspiration of mastering and subduing the created universe? It seldom happens that we are completely right or, for that matter, completely wrong. Our decisions are not reached all at once with brilliant clarity.

Our decisions slowly mature as we struggle against opposing ideas, slough off unacceptable aspects and grow from the contribution of friends and counselors. Even at the end of this long process, a wise man admits that he still has more to learn. He must cast off ingredients of hidden error and submerged prejudice and remain open to new insights and opportunities. This wisdom that we achieve applies best of all to that man who has a high and clear plateau of earthly existence. We as physicians have expended years persistently climbing, pulling and straining. Sooner or later the hills level off and we gain our vocation in life. From this plateau we look down upon the rest of the world. Here we can exert the fullest and most competent effort at the work assigned to us by Our Divine Being. We expect peace and serenity for we now can exercise our talents most serenely. From the height of this wisdom we hope to be most productive and good but it is on this plateau of wisdom that we begin to feel the full growing pain of monotony and dissatisfaction, of loneliness and misdirection.

When matters have been settled and reached maturity, we find they are already old and in need of rejuvenation. What we have acclaimed as a single achievement others are already dubbing old fashioned. Our culture at its height becomes closer to decay. Here is where faith is expected of us for our wisdom compels us to step forward into the unknown and plunge into mystery. We enter the struggle between the old and the new, between the tried and proven and the exciting and unknown. This is what I understand to be the tension between our wisdom and our faith.

(cont. next page)

In attempting to resolve my views I believe that faith resides in the intellect and ordinarily develops with the intellect. Whatever expands the mind has an immediate application to my faith. As the intellect grows, by grappling and struggling, by coming to grips with problems, by intuiting new insights and plunging into the unknown, my faith is challenged and with this challenge grows stronger. The Almighty challenges my faith by many mysterious forms of sufferings and by leaving many questions unanswered, however, if I were to answer every question my faith would be over rationalized.

Faith must leave a man strong and secure in the Almighty's love and pardon, but shaken and uncertain as to his own knowledge and capacity. Only then will man take another step off his plateau which will ultimately lead to a greater grasp of the Divine goodness. Each step plunges us into a greater mystery. Wisdom and faith will then grow together through the tension between them.

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A Cardiologist's View of Medical Ethics

Having been asked to submit an article on "Medical Ethics," I found it difficult to know where to begin. Medical ethics has become an "in" topic lately. The mere mention of this subject (whether at a cocktail party, a letter to the Editor in the newspaper, or at a medical school curriculum planning committee meeting) is sure to provoke a lively discussion, which will include an enumeration of the many injustices found in our medical care system as well as (very probably) an attack on the medical profession itself. In this growing age of "consumerism," we physicians are being asked more and more to redefine our positions on a multitude of medical topics of public interest. It is particularly appropriate to reflect on this subject during this holiday season of "peace on earth, good will towards men."

"Ethics" is usually defined as a system of behaviour that attempts "morally right" courses of action. "Medical ethics" cannot really be differentiated from the ethics of everyday life. Despite recent innovations in terminology, medical ethics still refers to the same questions which have traditionally concerned the physician: Is there sanctity to life without reservation? What is the patient's right to self-determination? Where ends the physician's responsibility to his patient or to himself and his family? How does the physician decide between conflicting equally valid moral issues? Who has the more "right" to life—the pregnant mother or the unborn child?

I have always found it most difficult to respond to such questions with an all-inclusive rule. I much prefer to consider each individual case, as I'm sure do most physicians. The cases which I, as a cardiologist, am most familiar with are those involving end-stage heart disease or deciding when to end cardopulmonary resuscitation. In any given case the more information that is available, the easier it is for me to make a decision. For example, if a 99-year-old patient with terminal cancer, who has been confined to a nursing home, has no living relatives, and who has been out of touch with reality for some time, is admitted to my service with an acute myocardial infarction, I find no difficulty in deciding that he should be made comfortable but that no heroic treatment is indicated. On the other hand, a case which I recently heard of lends itself to no such easy answer. This patient, aged 12 years, was the sole surviving son of a family who had already lost two older children (ages 17 and 19) to autopsy-proven idiopathic cardiomyopathy. He presented similar complaints as the other two children and was found to have a markedly enlarged heart by X-ray. Should this boy be submitted to expensive and uncomfortable tests? Should he be considered for a cardiac transplantation operation (which would require that his family move permanently to the transplant center area and which is of controversial long-term benefit)? As a physician, how much pain and trauma should I recommend to this family?

Most cases in life fall in this "gray zone" where easy answers are not readily available. How then is the physician supposed to act in an ethical way? I have found the most helpful general guideline to be to consider what I would want done were the patient a member of my own family. This principle is slightly different from the "Golden Rule" because I think I would wish more done at times for a member of my family than I would for myself. It is perhaps closer in feeling to Kant's Categorical Imperative or Sartre's Universal Action. It requires a loving, thoughtful, responsible approach to the most difficult problems with the full realization that I am quite capable of choosing the wrong course of action. Knowing that I will have to "live" with any decision I make is for me the crux of medical ethics. To paraphrase a recent sermon at my church, "Give of yourself, not until it hurts, but until *you* feel good about it."

Jesse G. Hafer, Jr., M.D.

Medical Ethics: Will Physicians And Priests Ever Start Talking?

Anyone who keeps even cursorily abreast of what is happening in the areas of biomedical research, psychology, and religion, with the subsequent ethical questions entailed by them, knows that the interface between medicine and religion has never been more obvious and important.

The doctor who attempts to keep up with what is current without including in his reading and research an openness and desire to acquire new understandings of the dynamics of religion (including ethics) and psychology is approaching the practice of medicine in a naive and one-dimensional manner.

Likewise, the priest, rabbi, or minister who doesn't wrestle with the magnitude of the ethical, moral, and religious issues facing the physician during the course of an average day is not likely to be providing his mentally or physically ill parishioners with a truly competent professional ministry.

From the perspective of a minister, this writer finds the isolation which exists in Hampden County between the medical and religious professional to be indicative of a "tunnel vision" approach to both the practice of medicine and the practice of religion. The absence of high quality seminars or colloquiums on relevant topics and the absence in area hospitals of staff who are highly trained priest/psychologists, of which there are many (otherwise known as chaplains which is a term I avoid here because of the pious hand-holding person/priest image it too often connotes), points to a narrow provincialism and ignorance of the benefits which can accrue to both professions when they study and work together.

The reason the benefits are worth looking into is because they fall into the areas of enhancing the "cure" and "care" of the patient and the benefits would enable both the priest (usage of term 'priest' to include ministers) and the physician to get handles on the mind-boggling ethical/moral/religious questions that are being raised daily in every hospital.

There are many roadblocks in the path of this continuing relationship between the professions of medicine and religion. First, physicians and ministers are the busiest people around. Second (and probably more of a roadblock) are the images ministers and physicians carry of themselves and of each other. For example, if a priest or minister is overwhelmed by physicians and places them on a pedestal second only to God, while constantly minimizing his own role, then the chance of the two meeting one another as equals is minimal. Or, if doctors choose to see the religious and emotional needs of their patients as less important than their organic or physical needs, to be treated by a fatherly pat or not at all, while only relating to the religious professional as someone who is meddling with "his" patient, then the opportunity for dialogue is obviously lost.

It seems to this writer that only the physicians and clergymen who have positive self-images, are open to cross-disciplinary learning and who have a deep respect for each other's professions stand a chance of coming together for some real sharing. It is in this context that the difficult oughts and ought nots of medical and religious ethics will get aired with the possibility of mutual and valuable insight and learning being the result.

The Rev. Gary A. DeLong
First Church of Christ
Longmeadow, Massachusetts

Letter to Editor

November 8, 1974

To All of the Doctors in the
Springfield Area

Dear Dr. Stevens:

This is a sincere thank you to all of you doctors for again supporting our local United Way campaign. You exceeded your last year's contributions by approximately $1,000 for a total of just over $28,000. Everyone in the United Way organization is very thankful for your help and certainly all of the money will be put to excellent use in the United Way program.

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Poet's Corner

To the Late O. N.— With Regards

The things that I write are not Ogden Nashian,
Although they resemble his, after a fashion.

It used to be that the practice of medicine
Was as simple as the life of Thomas A. Edison,
Or perhaps one might say that sipping these syrups
Was similar to taking that cup before stirrups.
Professional life was certainly much simpler,
And even orthopedics was a hell of a lot limpler.
But then the cardiologists let an unembellished four-chambered pump
Become an electronic, gadget-encumbered, enzyme-loaded lump.
And no matter how bare, without gift, is the giver,
There is now nothing as complex as the unclad, unadorned, sick or healthy liver.
And the certified urologist is now an apostate
Who refuses obeisance to the hypertrophied prostate.
And although Hippocrates recommended that no one should cut for the stone,
What surgeon in his right mind with a family and yacht to support would leave one alone?
Of human life, and the practice of medicine, there is nothing that would appear to be as certain, in the range,
As change.

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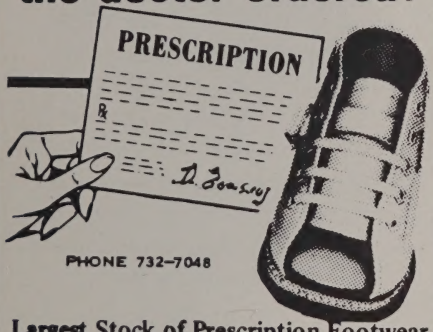

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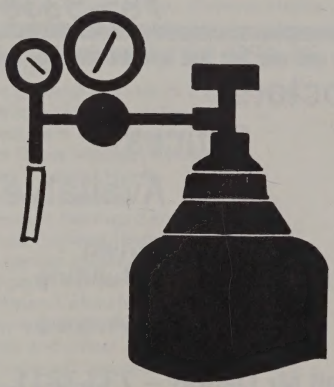

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